MCH Innovations Database

EVIDENCE-INFORMED POLICY DEVELOPMENT

NON-PUNITIVE APPROACH TO SUBSTANCE USE IN PREGNANCY

Location	Focus Area	Policy Type
New Mexico	Mental Health/Substance Use, Access to Health Care, Health Equity, Prenatal Care, Service Coordination/Integration	Big P Policy

Target Population
Pregnant people with substance use disorder and newborns with substance exposure

SECTION 1: POLICY DESCRIPTION

This policy was developed in New Mexico (NM) in response to the federal CARA amendment to CAPTA that stated all state child welfare agencies are required to ensure every baby born exposed to substances receives a Plan of Care and that the numbers of babies receiving Plans of Care are reported to the Federal Agency. The group was concerned that pregnant women may be receiving discriminatory treatment regarding drug screening and treatment of substance use in pregnancy; therefore, New Mexico decided to go beyond just reporting numbers of care plans but to try to put in place systemic changes and training of hospital staff to provide a non-stigmatizing, equitable response.

Led by the New Mexico Children, Youth and Families Department (CYFD) and the Department of Health (DOH), a task force consisting of healthcare providers, insurance care coordinators, state agency representatives, and other stakeholders has been working since September 2017 to articulate and implement New Mexico's response to CARA. The task force has been building partnerships with health insurance providers, medical organizations, hospitals, and reproductive justice organizations to facilitate access to support services for expectant mothers, newborns, and their families struggling with addiction. These partnerships were critical in the ultimate success of the legislation.

In January 2019 House Bill 230 was passed after much negotiation around language and many late nights testifying before legislative committees. This bill amended the Children's Code in New Mexico to require hospitals to create the Plans of Care for newborns with substance exposure and send the plans to CYFD and DOH, and to require managed care organizations to provide care coordinators for this population. The bill also stated that substance use in pregnancy should not, by itself, be considered a reason for a mandatory child abuse report. Of course, reports could still be made if warranted. The law went into effect in July 2019 and over the next eight months staff traveled the state training hospitals and medical providers on the requirements of the law and its intended purpose. Evaluation of the project is ongoing, and we now have data for the first two quarters of 2020, which included 481 Plans of care. As of early 2021, 1,120 Plans of Care have been submitted.

EVIDENCE TO SUPPORT POLICY APPROACH

New Mexico (NM) has one of the highest rates of any state when it comes to opioid and meth use, and over the past decade NM has seen skyrocketing rates of neonatal abstinence syndrome (NAS). According to a report released by the New Mexico Department of Health in November 2018, the rate of NM newborns exposed to addictive substances in utero increased 324% between 2008 and 2017. This compares to an increase of 207% nationwide in the same timeframe. Infants born exposed to addictive substances may initially struggle to survive and then struggle with health, learning, and social challenges for the rest of their lives. Additionally, in NM 72% of births are paid for by Medicaid in contrast to 55% nationally. Supporting these children through infancy and into adulthood is costly to families and to society.

The benefits of screening for substance use in pregnancy and providing treatment are well documented, starting with the Kaiser studies from the 1990s. Punitive approaches to substance use in pregnancy have been shown to worsen outcomes, mostly because they deter women from seeking medical care for fear of having their children taken away, and they lead to higher rates of NAS.

HEALTH EQUITY

Provider discrimination has been reported anecdotally on the New Mexico PRAMS survey of pregnant women who recently gave birth. To reduce possible stigma and/or discrimination, this policy requires plans of care for ALL newborns born exposed to substances rather than automatically referring some families to CYFD and not referring others. It also mandates supports and services, including care coordination services, be offered to all families.

The work of the task force (two plus years prior to the legislation) included focus groups with women who had experienced substance use in pregnancy, as well as those who had been enrolled with CYFD. It also included organizations led by women of color (NM Birth Equity Collaborative, Bold Futures, TEWA Women United, etc). In developing webinar trainings on the policy, focus groups were utilized to get input from those most impacted.

Through the evaluation this policy, the team is surveying participants to get their perspectives on discrimination and stigma in regard to their pregnancy experience. Data is also being collected on who receives the Plans of Care to ensure that they are being done universally and to assess the long-term impact of the plans.

SOCIAL & POLITICAL CONTEXT

As stated, a multi-agency CARA task force spent two years building partnerships with health insurance providers, medical organizations, hospitals, and reproductive justice organizations to facilitate access to support services for expectant mothers, newborns, and their families struggling with addiction prior to proposing the legislation. These partnerships were critical in the ultimate success of the legislation. One of the legislative champions was also the Policy Director for a local reproductive justice organization and had served on the CARA task force. This legislation was a cross-agency effort which included testimony from CYFD, DOH and the University of NM. Surprisingly, the biggest opponent was the Social Work Association and their lobbyist, due to concerns expressed by foster parents. This misunderstanding about the intent of the legislation was worked out by meeting with those groups and the bill passed its final hurdle on the last day of the session.

Currently, there is strong political support for the policy, and the new Governor (since Jan. 2019) is supportive of interagency collaboration so that has helped also. The evaluation is a key component as legislators are very interested to see the results of this legislative change. As more data is collected and evaluated those questions will be able to be answered more thoroughly.

SECTION 2: CONSIDERATIONS FOR FUTURE POLICY DEVELOPMENT

LESSONS LEARNED

1. Take time to listen to a broad range of stakeholders and include them in the planning before proposing any legislative changes. This should include voices from the communities most impacted, as well as those who will be tasked with carrying out the policy.

2. Try to include dedicated funding in any legislation so it does not become an unfunded mandate.

3. Any state-wide policy change requires extensive training to ensure proper procedures are followed and that those tasked with carrying out the policy understand the background and intent. This training needs to be accounted for in terms of staff time.

FUTURE CHANGES

General

Training and education for providers and hospital staff to implement the policy is a critical piece of this policy. In future policy development efforts, such training could be explicitly written into the policy to ensure that such efforts are adequately funded and planned for.

Health Equity

Recognizing that women of color with substance use disorder can and do experience intersecting discrimination because of implicit bias and racism, it is important that implicit bias training for providers and hospital staff who will be implementing the policy be explicitly included in the policy during development.

Stakeholder/Advocacy Efforts

Throughout development, soliciting input and feedback from birthing people with SUD was critical to inform policy development. Such efforts should be prioritized in future policy development efforts as well.

FUNDING

The biggest hurdle in doing this work in NM was that the work was largely unfunded. Some staff time from CYFD and DOH personnel was allocated and had to be increased during the training phase. Recently there has been a small amount of private foundation funding obtained that is helping the CARA program to hire more staff.

ADDITIONAL RESOURCES

These resources were helpful in supporting the need for this policy in New Mexico:

- Policies That Punish Pregnant Women for Substance Use Are Linked to Higher Rates of Newborns Experiencing Opioid Withdrawal (RAND)
- A Public Health Response to Opioid Use in Pregnancy (American Academy of Pediatrics)

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